

# The Cloak

VA VISN 3 Palliative  
Care Initiative

Volume 3, Number 1

January 2006

## VISN 3 Palliative Care Update *Submitted by Therese Cortez, NP and Carol Luhrs, MD*

From our last **Cloak** update in June 2005, we continue to advance our VISN Palliative Care Program through ongoing quality improvement, staff education/mentorship, and partnership with the hospice community on a local and state level.

The ongoing VISN 3 **After Death Bereaved Family Member Interview** has provided us valuable information about the end of life care provided to the veterans and their families. We have been able to identify areas of opportunity to improve our delivery of care, such as providing information about practical issues related to the veteran's death and improving emotional and spiritual support for the family. We are continuing our VISN feedback meetings with the individual teams every other month to review over site-specific After Death Survey results, Palliative Care Consultation team activities, review of the site Performance Improvement plan, and other identified projects at each site. We continue to look forward to our ongoing feedback with the teams to assure the quality of the Palliative Care Programs at all sites.

During our VISN Palliative Care Quarterly Meeting in September 2005, several **VISN awards** were given by Mr. Farsetta and Dr. Feldman. Zeld Foster, LCSW, DSW, former Social Work Chief of Brooklyn VAMC, was recognized by the VISN for her outstanding contribution to Hospice and Palliative Care. Paul Stolz, LMSW was given the 2005 Outstanding Individual Achievement Award. Brooklyn PCCT was given the 2005 Outstanding Team Award.

Our September VISN Quarterly Meeting also featured **Susan Gerbino, LCSW, PhD**, who spoke about complicated mourning in adults. Her compelling lecture highlighted the importance of the Palliative Care Team members to appropriately assess family members/ caregivers for complicated grieving and ensure referral to bereavement support services.

We opened the beginning of FY 2006 with the continuation of the Phase II local **HVP Roundtable Discussions**. NY Harbor hosted their Phase II local HVP meeting on October 12, 2005, while Hudson Valley hosted their local roundtable discussion on November 16, 2006. Representatives from all hospices in their catchment regions attended the Phase II meeting, and both HVPs have agreed for ongoing meetings to ensure care coordination for the veterans and their families. The Long Island HVP continues to sponsor joint meetings to enhance the seamless transition of care for veterans needing hospice care in the community. We look forward to the continuation of the local Phase II HVP roundtable discussions throughout the other sites in the VISN.

Our joint collaboration with the local hospices enhanced the success of VISN 3's participation in the **Caring Coalition of Metro NY's Proxy Week**. During November 2005, all local HVPs were encouraged to sponsor joint events to promote education to patients and their families about advance directives, hospice and palliative care. Each site in the VISN sponsored a local event with their regional hospices. A total of 940 Advance Directives were distributed by VISN 3 during this Proxy Week events.

With the growth of the HVP at the local level, activities at the state level continue the collaboration between the VA and hospice community. In an effort to further expand our local Hospice Veteran Partnership and achieve the proposed National HVP Outcome Measures, the HVP Steering Committee recently developed a brief survey for the community agencies providing hospice care to the veterans. The survey was distributed by HPCANYS and NJHPCO during September to November 2005. This survey will be utilized by the local HVPs to get a better assessment of the end of life services available in the community. Knowledge of the services provided by our community agencies

will ensure the delivery of end of life care provided to the veterans and their families. All local HVPs are encouraged to review the results of the survey and continue the ongoing dialogue with their local partners in the Phase II HVP Meetings.

Another exciting event for our program was the **Circle of Life Site Visit** on December 9, 2005. VISN 3 is one of the eight finalists for the Circle of Life Award. The Circle of Life Award honors innovative programs in palliative and end of life care. The goal of the award is to increase understanding and awareness of the importance and value of providing high quality end of life care. The Circle of Life Award is sponsored by the American Hospital Association in conjunction with the American Medical Association and the National Hospice and Palliative Care Organization. Leaders of the VISN Palliative Care program, the PCCT Coordinators, Co-Chairs of the workgroups, Mr. Farsetta, Dr. Feldman, and Kathy McMahon from HPCANYS presented our comprehensive program to the Circle of Life Site visit committee. It was an exhilarating day for all the members. We thank everyone who braved the snowstorm to be present at the site visit and all of the members of the teams for your enthusiasm,

and to the valuable work that you deliver to our veterans and their families. Thanks for your efforts for making our Circle of Life visit a success. We hope for a very positive outcome!

In 2006, the initial projects of our workgroups will include the development of a VISN Bereavement Policy and Program by the Community Outreach hard workgroup and a focus on symptom assessment and management by the Standards of Care Workgroup

As we look forward to the continuation of a prosperous year, we once again thank you for your commitment.



### VISN 3 Congratulates Trula Hudson, CNA

VISN 3 is proud to congratulate Trula Hudson, CNA for passing the Nursing Assistant Hospice and Palliative Care Certification Exam. Trula Hudson, a nursing assistant at St. Albans is the first nursing assistant in VISN 3 to pass the certification exam, which is sponsored by the National Board for Certification of Hospice and Palliative Nurses. Congratulations Trula!

### Brooklyn Palliative Care Consultation Team Recognized for Outstanding Achievement in 2005

Every year, VISN 3 recognizes the PCCT that has demonstrated significant growth and development during the previous year. Based on the goals outlined in the FY 2005 Strategic Plan, each of the PCCTs were evaluated on their overall performance and impact of palliative care in their site. During the September 20, 2005 VISN Palliative Care Quarterly Meeting, Brooklyn PCCT was recognized as the Outstanding Palliative Care Consultation Team for 2005.

Brooklyn PCCT has implemented innovative approaches to the delivery of end of life care: Palliative Care Unit in acute care, Outpatient Palliative Care Clinic, and the development of the Palliative Care-

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### Cont. from P. 1 article on Brooklyn Team Award

During FY 05, members of the PCCT, which include Alice Beal, MD, Mary Drayton, NP, Nancy Haliskoe, NP, Lillian Reyes, NP, Louisa Daratsos, LCSW, Maria Pacione, LCSW, Sabrina Kim, LCSW, and Father Thomas Mullen promoted Palliative Care throughout all venues of care at the Brooklyn facility, and emphasized the importance and benefits of Palliative Care Consultation in the intensive care setting. The team was also the first VA to implement Schwartz Rounds, a nationally recognized interdisciplinary program designed to promote empathy among health care providers. As a result of their participation with this project, they have been instrumental in developing the rounds at two other VA facilities in other VISNs.

VISN 3 recognizes the dedication and hard work of the members of the Brooklyn PCCT. Congratulations Brooklyn PCCT for your outstanding performance during 2005! We look forward to the great work you and the Palliative Care Teams in the VISN will continue to achieve this year!



The Brooklyn Palliative Care  
Consult Team



### A PERSPECTIVE FROM THE TRENCHES

ROBYN ANDERSON, APRN

Palliative Care is a rapidly expanding field in health care. Endless possibilities exist for research and education as the concept of providing comprehensive care to patients nearing the end of life gains popularity and momentum. The number of journals and educational programs focused on palliative care expands regularly; new research funds in this area are becoming increasingly available. Within our VISN, there has been a tremendous push to expand Palliative Care. There has been a heavy emphasis on methods to effectively collect data and develop relationships with community resources. Accolades for the VISN 3 Palliative Care program are abundant and opportunities for education, research and publication abound.

As our programs expand, the demands upon the clinicians who provide the care increase. The number of veterans receiving palliative care continues to increase. In the Bronx, palliative care consults increased by almost 30% while staffing levels actually decreased by close to 40%. At the same time, requirements for documentation, committee memberships, educational activities and community outreach continue to increase. The result is overburdened staff that feels frustrated and begins to suffer from burn-out.

Those who practice in the field understand the numerous and conflicting demands placed on the clinician. The clinical work is time-consuming and emotionally draining. The rapid development in the field demands constant attention to the literature and modification of practice to meet rapidly changing standards. Ongoing education of other health professionals requires additional time and resources. Although the rewards of this work are great, the demands can be daunting.

(con't on page 4...)

### Palliative Care: A Psychological Perspective

BY: BROOKE MYERS SORGER, PHD  
Interprofessional Palliative Care  
Fellow

As patients and families face their own death or that of their loved one, they develop new perceptions, thoughts, and feelings about events of the past, present, as well as the time they face ahead. As a result, such times can be psychologically complex and confusing, clouded by intense thoughts and emotions. Decisions about everyday living may become difficult; as everyday is endured but also (in most cases) cherished. As with most moments in life, each person faces illness and death in a unique psychological way. There is much in the future that is unknown. Many face losing their identities – not being the same person they once were. They can no longer produce the same way that they used to. They do not work; they cannot even care for their own needs; they may feel demoralized and lost. They need to find a new way of understanding who they are and how they fit in.

Some look back over their lives and want to tell their story; speak about what they are most or least proud of; talk about their children, their friends, what has mattered most to them. They want to offer advice; offer to someone else what has been most meaningful to them. Others do not want to talk at all. They do not want to admit to having a disease or that they are going to die. They have always denied and want to continue to deny for better or for worse. Family members react in a similar manner. They may want to share about their loved one or they do not want to share at all. Some begin grieving at the beginning of the illness and others only when the end appears.

A psychologist in palliative care can understand how such behaviors, thoughts, and feelings at the end of life (for both patients and families) fit into a long preexisting fabric of well established ways of being (e.g., what can sometimes appear as irrationality may be very consistent in the fabric of a patient's life.) We can recognize and decipher when symptoms are normal versus psychopathological versus existential and make recommendations and / or treat according. Or simply, we can be present and listen.



### NOTE FROM THE EDITOR



You will see that this newsletter looks a little different...we have had a turnover in the Editorial Staff and we decided to change the look for 2006! In the interest of time, we made the decision to go ahead and publish **The Cloak** even though it does not have its usual multitude of photographs. We expect those to return in the next issue. Thanks to everyone for your patience while we were getting this issue together.

Happy New Year to all of you from all of us at the Bronx-New York Harbor GRECC!!

Judy Howe

## Pharmacists' Role in Palliative Care

By: Trinh T. Bui, PharmD  
Interprofessional Palliative Care Fellow

Nationally, clinical pharmacists are few in number, and specialist pharmacists are even fewer in number, especially in hospice and palliative care. Pharmacists play a vital role in the interdisciplinary teamwork of hospice and palliative care. Symptom management is a large component of hospice and palliative care, and as result patients receive complex medication regimens. In order to maintain optimum symptom control, pharmacists are needed for medication review. In addition, disease progression, organ function change, and complex medication regimens put patients at risk of drug-drug and drug-disease interactions. In addition, patients are more likely to have fears of adverse reactions.

Literature shows pharmacists' interventions (>60%) significantly improved patient care, suggested more effective therapy and more cost-effective pharmacotherapy. Most interventions involve education of inappropriate drug regimens, warnings of drug interactions and therapeutic drug monitoring for inpatient palliative care units. The role of a pharmacist in the outpatient palliative care clinic is slightly different. Improvement of taking medication history, education of patient and caregiver understanding of drug regimens, and overall management of palliative care clinic by pharmacists with more than 80% of their interventions are beneficial to patients.

Therefore, pharmacotherapy is an important part of physical and psychological symptoms management in hospice and palliative care, and pharmacists' knowledgeable in this area should be a beneficial resource to other clinicians. As a new practitioner, I realize that there is little representation of pharmacists in the hospice and palliative care movement, and this role is often overlooked when developing an interdisciplinary team. Perhaps, pharmacists are often seen in the distributing role in both 216. Inpatient and outpatient settings and the role of clinical pharmacists is not widely recognized. However, in the advance of the growth of the aging population, there will be an increase demand of clinical pharmacists with specialty in symptom management. In the mean time, pharmacists should be encouraged to take an active role in hospice and palliative care.

## My Palliative Care Perspectives

By: Ryuichi Sekine, MD  
Interprofessional Palliative Care Fellow

My name is Ryuichi Sekine. Why do I care about palliative care? I was born in a Buddhist temple in Japan and raised to become a priest. Since my childhood, I was helping funeral ceremonies and other works at the temple with my father and grandfather. With this background, I came to be more interested in the area of death and dying and decided to deal with it as a physician as my lifework. Since I found there was no well-recognized post-graduate clinical training in my country in palliative care, I decided to come to the US to pursue the clinical training in palliative care. I came to NY in 2001 and had 3 years of internal medicine residency at Beth Israel Medical Center, NY.

Subsequently, I had a one-year pain medicine and palliative care fellowship at the same facility, where I learned how to manage all kinds of pain problems in chronic pain, post-operative/acute pain patients as well as palliative care/hospice patients. I had some exposure to palliative care for several months during the previous fellowship but I did not feel enough to become a full-fledged palliative care specialist in the field. That is the reason I pursued this interdisciplinary palliative care fellowship here at the Bronx VA.

This Bronx VA interdisciplinary fellowship is very well fit with the concept of palliative care. Team care is almost mandatory in palliative care and we have an excellent team consisting of a pharmacist and a psychologist as well as physicians. I really enjoy working in this team and found this teamwork very productive, effective, and stimulating.

This team approach was very new to me but I came to understand more about the importance of this team care specifically in palliative care. Palliative care is expected to accommodate all different types of patients' needs in terms of treatment preferences, helping their social situations, and understanding and supporting their spiritual concerns etc. These are extremely challenging task and cannot be managed by one single person.

These are extremely challenging tasks and cannot be managed by one single person. Total care at the end of life is possible only through approaching to the patient from all the possible dimensions related to the patient's clinical issues.

End-of-life care is very unique in that health care providers can possibly connect very intensely with the patient and have the privilege to touch the deepest, core part of human beings. I appreciate all my patients letting me share their last part of life. I would like to continue improving my skills in palliative care with all my effort and to understand better about human beings through my profession. After I complete my fellowship training in the US, I am planning to return to Japan and help improve the clinical level of palliative care overall there.



## LESSONS FROM A FUNERAL

By Chaplain Paul Swerdlow

There I was sitting at a funeral of a man whom I have known for many years. I listened to speaker after speaker offering words of praise. My eyes focused on the coffin and the man inside, knowing that, in death, he could not hear these words. I wondered if all those who were speaking said these complimentary words to him while he was alive. I looked around at the other people at the funeral and wondered if they had said all of the nice things they felt about him to him. I know that I didn't. My first lesson from that funeral is that if I have anything nice to say about someone, I am not going to hold back. If you would like to say something nice about me, please don't wait funeral.

My second lesson was about tomorrow. How often have we had wonderful dreams of what we would like to do and what we would like to have? We'll do it some day we promise ourselves. After spending their entire married life in one house, they finally made the move and bought a beautiful new home in an over 55 community. It was a new development. While their home was being built, he became ill. Finally the home was completed and they moved in. Two weeks later, he died. It is time to take your dreams out of mothballs and make them happen because some day may never happen.

There is an old Jewish saying "repent one day before your death." To which the rabbi asked how can we know the day of our death? We can't. Therefore it is incumbent upon us to repent each day. My friend was my age. I realized that it might have been me. What unfinished business do I have? Whom do I need to get in touch with? What relationships do I need to mend? As these questions raced through my mind, I remembered an ancient blessing and silently said these words: "Blessed are you Eternal God, ruler of the universe, who has given us life, sustained us and enabled us to reach this day."

### Editor's Note:

Your article, case, poem, photograph, or reflection could go here in the next issue of *The Cloak*!

Submissions are due for the Spring newsletter no later than March 1, 2006. Please e-mail them to Miriam Gonzalez at [miriam.gonzalez2@med.va.gov](mailto:miriam.gonzalez2@med.va.gov)

If you have questions, please call Miriam at 718-584-9000, ext. 3837

## PALLIATIVE CARE:

## AN MD'S PERSPECTIVE

By: T. Kutzy, MD Interprofessional  
Palliative Care Fellow

Doctors are healers. However, this statement is not as "cut-and-dry" as it may appear. If a doctor is asked what it means to heal, odds are that nine-times-out-of-ten, he will state that it means to cure a disease, either medically, surgically or many times, using both modalities. However, a question remains: is curing a disease equivalent to healing or is it just part of a larger whole--that is where a Palliative Care physician might provide a different answer.- What is healing?

**Webster's dictionary says:**

**heal** = Pronunciation: 'hE(&)l

Function: verb Etymology: Middle English *helen*, from Old English *h[AE]lan*; akin to Old High German *heilen* to heal, Old English *hAl* whole -- more at

**WHOLE** transitive senses

**1 a** : to make sound or whole <heal a wound>

**b** : to restore to health

**2 a** : to cause (an undesirable condition) to be overcome : **MEND** <the troubles... had not been forgotten, but they had been healed -- William Power> **b** : to patch up (a breach or division) <heal a breach between friends>

**3** : to restore to original purity or integrity <healed of sin>

In this definition, there is no specific mention of disease cure, although the phrase "heal a wound" is used in context of the definition "to make sound or whole", which can apply to anything, and not just a pathological disease state.

The reason that I am pointing this out is because as a Palliative Care physician, I am a healer, but I am not necessarily curing a disease; on the contrary, many times I am letting an illness run its course while providing comfort care to ease any associated suffering from the illness and its complications. Both colleagues in other specialties and people that are not in the medical field have questioned what I do in regard to how I could practice this type of medicine where my goals seemingly are not in line with my training as a physician. Again, this stems from what people's perception of what it means "to heal" is. At first, I answer jokingly by saying that because of my initial training as an internist, this is the only aspect of Internal Medicine with a clear endpoint. I then explain the philosophy behind Palliative Care, and why it is so important.

Palliative Care is an interdisciplinary subspecialty, whose goal is in line with the first part of the definition of "heal": to make sound or whole. We, being the palliative care team, are attempting to do this at probably the most difficult time in one's life to achieve this--when one is faced with their impending death. In this sense, we are trying to restore soundness and wholeness in all aspects of a person's life, including, but not only physically, emotionally and spiritually. I am most involved with the physical aspects of one's suffering, so my work is primarily with symptom management, and especially pain management. I feel that although I am not curing the primary illness, for example, cancer, but in a sense I am curing many of the ramifications associated with the illness. Again, the ramifications transcend well beyond just physical symptoms, which is why I work as part of a team to approach a person's needs more holistically.

As a surgeon, one feels rewarded with a successful operation. As an internist, one feels rewarded with the diagnosis and management of a debilitating or potentially debilitating medical condition. As a Palliative Care physician, I feel rewarded when I know that I have helped to ease one's pain and suffering, while helping to bringing wholeness to their life to the point where they can die as peacefully as could be possible.



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From page 2 (Trenches)

The purpose of research and education are to improve clinical care and patient outcomes. Therefore, as research and education in the palliative care arena expand, it would seem appropriate that resources directed at the provision of clinical care would also increase.

The current health care arena seems to place more value on research, publications and awards than on the care of the patients which they are aimed at improving. Experienced and dedicated clinicians are not recognized for the contributions they make, despite the fact that the clinical work is the entire purpose of all the other activities. When the ever-increasing workload is factored into a lack of recognition, it becomes apparent why outstanding clinicians leave the patient care arena in an effort to avoid burnout or, even worse, the feeling that they are unable to provide a high level of quality care to our most vulnerable population.

Perhaps future research in palliative care should look at the appropriate staff to patient ratios or the appropriate number of hours a palliative care can reasonably spend providing direct patient care before they begin to suffer from signs of burn-out. With greater clinician involvement in formulating research questions, research data might be more relevant and lead to improved outcomes.

Increased support of clinical programs would also benefit education programs as experienced, expert clinicians demonstrate the practical application of concepts learned in formal education programs. Perhaps the focus in healthcare should return to providing high quality care at the bedside with the focus firmly on the patients we serve, not on the number of grant dollars brought in or articles published.



## Upcoming VISN 3 Events

- VISN-wide Case Conference via videoconference — February 16th & March 16th — noon to 1 pm
- Quarterly Education Meeting — April 18, 2006, 8:30 — 2 pm — Bronx VA, 3D-22 (attendance is mandatory for all PCCT members!)